PROGRESS NOTES / CONTACT LOG

Case Management Service Agreement Plan

Client Name:_____

Ref.	Date	Progress Notes/Contact Log

Reference: P-Phone L-Letter CL-Certified Letter M-Message F/F-Face to Face

Montana Breast and Cervical Health Program
Acknowledgment of Refusal to Consent to Diagnostic Tests or Treatment

Patient Name (Print):_____

My health care provider has recommended further diagnostic testing/treatment to me. I understand these diagnostic tests will help my health care provider diagnose cancer or the treatment recommended for cancer.

I have read and understand the paragraph(s) below that pertain to my decision to refuse diagnostic tests and/or treatment.

The health care provider named below has explained to me that I need **diagnostic test(s)** to determine if I have breast or cervical cancer (circle one). The test(s) that are recommended to me include:

_____
_____

If the diagnostic test(s) have been completed, I have read and understand the result(s) and the diagnoses that are listed below:

_____
_____

The health care provider named below has explained to me that I need **treatment** for breast or cervical cancer (circle one). The treatment recommended to me is:

_____
_____

My health care provider named below has explained to me that the recommended test(s)/treatment are for breast or cervical (circle one) cancer and the likely consequences of refusing the test(s) or treatment, if I have cancer are:

_____
_____

I understand that the refusal of the test(s)/ treatment recommended by my health care provider may endanger my health, or could lead to my death. Knowing this, I refuse to consent to such recommended test(s)/treatment.

I hereby release my doctor/health care provider, _____(Print Name)
and the Montana Department of Health and Human Services (DPHHS) from any liability or responsibility for not providing the test(s)/treatment described and referred to above.

_____(Date)_____
Patient signature

_____(Date)_____
Witness

Montana Breast and Cervical Health Program
Transportation Prior Approval for Case Management

Name of Client: _____Date:_____

1. Administrative Site**:**_____

2. Transportation services needed and estimated amounts:_____

_____

_____

3. What are other payment sources you will be using? _____

_____

4. Brief summary of services needed, location and date of services:_____

_____

_____

To be completed after prior approval:

Amount of funds approved:_____

_____

Approved by: _____

Phoned response to CM_____
Faxed response to CM _____
Mailed response to CM _____